Arkansas Wholesale Distributor of Legend Drugs Application

Completion of this application form is necessary for consideration for a permit to operate as a wholesale distributor of legend drugs pursuant to Arkansas Pharmacy Law and Regulation. (You may download statutes and regulations from our website. The web address is: http://www.arkansas.gov/asbp/ Regulations for wholesale distributors of legend drugs are contained in Regulation 8.) Disclosure of this information is voluntary. However, failure to disclose all requested information may result in this form not being processed and may subsequently result in denial of this application. All candidates for licensure, renewal, and/or examination have an obligation to update and supplement the information and responses on this application if they change. Failure to supplement the information and responses provided on this application may result in denial or other appropriate action. All information provided must be accurate. Please note that the information provided on this application is subject to the public information laws of this jurisdiction.

Carefully follow the directions on this application form. In addition, note the following:

1. Type or print legibly with black or blue ink only.
2. The registration and application fees are NOT refundable.

Please complete the entire application and submit additional pages as needed or as indicated in the instructions.

Supporting Documentation and Fees

Submit the following documents and fees:

1. This completed application (4 pages.)
2. A copy of your wholesale distributors license/permit issued by the state in which the wholesale distributor is located.
3. A copy of the latest inspection report issued by the state in which the wholesale distributor is located.
4. Copies of all federal licenses and permits.
5. A copy of your product liability insurance.
6. An application fee. See Part V on the application.
7. Supplemental information as specified in the application.

Your application is NOT considered complete until all supporting documents and fees have been received by the Arkansas State Board of Pharmacy.

Arkansas State Board of Pharmacy
101 East Capitol, Suite 218
Little Rock, AR 72201
Telephone: 501-682-0190

FOR OFFICE USE ONLY

License # _____

Date Issued: _____

Fee Submitted:

Application for a Wholesale Distributor of Prescription (Legend) Drugs Permit

PART I: GENERAL INFORMATION					
1.	*Business Name*				
	dba				
2.	*Physical Address*				
	Street				
	City				
	State		*Zip*		
3.	*Mailing Address*				
	Street or PO Box				
	City				
	State		*Zip*		
4.	*Telephone Number*		*Fax Number*		
5.	*Website*				
6.	*Type of Operation (check all that apply)*	___ Manufacturer ___ Wholesale Distributor ___ Repacker ___ Medical Gas Distributor ___Other *		___ Jobber ___ Warehouser ___ Retail Pharmacy ___ Hospital Pharmacy ___ Reverse Distributor	
	**If other, please provide a description of your operation on a separate sheet.*				
7.	*Methods of Distribution (check all that apply)*	___ *Products shipped directly to pharmacies* ___*Products shipped directly to veterinarians* ___*Products shipped directly to physicians, dentists, podiatrists* ___*Products shipped to distributors, wholesalers, repackers, jobbers* ___*Reverse distribution* ___*Other (please explain on a separate sheet)*			
8.	*Classes of Drugs Distributed (check all that apply)*	___ *Legend drugs - human* ___*Legend drugs – veterinary* ___*Controlled substances – human* ___*Controlled substances – veterinary*			
9.	*Controlled Substances you plan to ship to Arkansas*	*Check all that apply* *Schedule II____ Schedule III____ Schedule IV___ Schedule V____*			
10.	*DEA Number*	_____ *or [ ] Applied for [ ] Not needed*			
11.	*Name of DEA Registrant*				
12.	*Person with whom the Arkansas State Board of Pharmacy may communicate regarding this application:*				
	Name		*Position*		
	Telephone		*Cell Phone*		
	Email				
13.	*Is this application made as a result of a change of ownership?*			[ ] Yes [ ] No	
14.	*Has the applicant ever been licensed in Arkansas?*			[ ] Yes [ ] No	
15.	*Does this business conduct operations at more than one location that ships drugs into Arkansas?*			[ ] Yes [ ] No	

16.	How long has the applicant been engaged in the wholesale distribution of drugs?	_____*years*

PART II: Applicant History

Please answer each of the following questions by putting a check (√) in the appropriate box on the right. You must answer each question with a "Yes" or "No" response as no other response is acceptable. All "Yes" answers MUST be explained in detail in a separate SIGNED and NOTARIZED affidavit. The affidavit should include all relevant dates, and identify the relevant jurisdiction and/or entity involved. Failure to disclose any of the requested information may result in the denial of your application or other appropriate action. NOTE: If you answer "Yes" to any of the questions below and you have already submitted a detailed affidavit to the Arkansas State Board of Pharmacy explaining your response you need not submit another detailed affidavit. Please note the date of your previous submission next to the applicable question(s).

17.	*Is the applicant currently under investigation in any state in which it is licensed?*	[ ] Yes [ ] No
18.	*Has the applicant ever been the subject of disciplinary action or been sanctioned by any licensing authority?*	[ ] Yes [ ] No
19.	*Is there any disciplinary action pending against the applicant by any licensing jurisdiction, the USDA, Drug Enforcement Agency or any state drug enforcement authority?*	
20.	*Has the applicant ever been convicted of violating any federal, state or local law related to drug samples, wholesale or retail drug distribution, or distribution of controlled substances?*	[ ] Yes [ ] No
21.	*Has the applicant ever been convicted of violating any federal, state, or local law related to the practice of pharmacy?*	
22.	*Have any of the applicant owners, officers, directors, or stockholders ever been convicted of a felony or crime involving the practice of pharmacy? (If the business is a corporation, you need not include stockholders in this question unless they currently serve as officers or directors of the applicant business, or own more than twenty percent (20%) of the company stock.)*	[ ] Yes [ ] No
23.	*Has any sanction or disciplinary action been taken regarding any license, permit or registration issued to the applicant, officers, directors, partners or stockholders involving the practice of pharmacy? (If the business is a corporation, you need not include stockholders in this question unless they currently serve as officers or directors of the applicant business, or own more than twenty percent (20%) of the company stock.)*	[ ] Yes [ ] No
24.	*Are there any charges pending against the applicant, officers, directors, partners or stockholders involving the practice of pharmacy? (If the business is a corporation, you need not include stockholders in this question unless they currently serve as officers or directors of the applicant business, or own more than twenty percent (20%) of the company stock.)*	[ ] Yes [ ] No

PART III: BUSINESS OWNERSHIP

25. Business Name:_____

Select the appropriate form of ownership from the following choices.

[ ] *Sole Proprietorship- Please provide the name and address of the owner.*

_____

_____

_____

[ ] *Partnership Name:* _____

General Partnership – *please provide the names and addresses of all partners. You may attach a list of partners if there is not enough space.*

_____

_____

_____

_____

Limited Partnership – *please provide the names and addresses of all partners and indicate if they are general partners or limited partners. You may attach a list of partners if there is not enough space.*

_____

_____

_____

_____

[ ] *Corporation Name:* _____ [ ] Check if Subchapter S Corporation

Employer Identification Number: _____

State of Incorporation:_____

Is this corporation publicly traded? [ ] Yes [ ] No

Is this corporation a subsidiary of another (parent) company or corporation? [ ] Yes [ ] No

If yes, please explain your relationship to your parent company on a separate sheet or provide a schematic which illustrates the relationship.

Officers

President _____

Vice President _____

Secretary _____

Treasurer _____

Director _____

If you need additional space for the corporate officer/director list, please attach the list as a separate document.

[ ] *LLC Name:* _____

Officers

President

Vice President

Secretary

Treasurer

If you need additional space for the corporate officer/director list, please attach the list as a separate document.

[ ] *LLP Name:*_____

Please provide a general description of your company organization.

_____

_____

Please provide the names and addresses of all partners. You may attach a list of partners is there is not enough space.

_____

_____

_____

Company Name:_____

PART IV: DOCUMENTATION

26. *Attach copies of the following documents to this application, or an explanation of why these documents are not included:*

(A) *If the applicant is not an Arkansas business, a copy of the license/permit issued by the state in which the wholesale distributor is located.*

(B) *If the applicant is not an Arkansas business, a copy of the latest inspection report for the wholesale distributor issued by the regulatory agency that performs such inspections in the state in which the business is located.*

(C) *Copies of all federal licenses or permits.*

(D) *A copy of your product liability insurance.*

PART V: APPLICATION FEE

Check **one** of the following options:

[ ] This is a new business.
What is the date this application will be submitted to the Arkansas State Board of Pharmacy? Add thirty days. What is the new date?_____
If this date falls in an even numbered year, the fee is $300.00
If this date falls in an odd-numbered year, the fee is $450.00

[ ] This is a change of ownership of a current license holder.
The fee for a change of ownership is $150.00.

PART VI: Certification *Please read carefully and sign below.*

I swear, or affirm, that all statements made herein and on the attached forms are true and correct. All of the provisions of Arkansas laws and regulations related to the wholesale distribution of drugs into Arkansas will be faithfully observed during the period any permit issued may be in force and effect.

This business employs adequate personnel with the education and experience necessary to safely and lawfully engage in the wholesale distribution of drugs; meets the minimum requirements for the storage and handling of prescription drugs specified in Regulation 08-00-0008; meets the minimum requirements for the establishment and maintenance of prescription drug distribution records specified in Regulation 08-00-0008; has written policies and procedures as described in Regulation 08-00-000; maintains ownership/ management/employee records as specified in Regulation 08-00-0010; complies with all applicable federal, state and local laws and regulations; and, before shipping to a recipient in Arkansas, will determine that the recipient is appropriately licensed and authorized by law to purchase and possess prescription drugs.

I understand that the Arkansas Pharmacy Lawbook contains the statutes and regulations related to the wholesale distribution of drugs into Arkansas, and is available online at the Arkansas State Board of Pharmacy website. I have read regulations 08-00-0001 through 08-00-0014 and will abide by them.

I will notify the Arkansas State Board of Pharmacy if any information contained in this application for a permit changes within thirty (30) days of the change.

By virtue of filing this application, I do solemnly swear or affirm that I am of good moral character, and that I understand the instructions and terms as set forth in this application form, that I have personally completed this form, that the information given in this application is true, correct and complete to the best of my knowledge. I authorize the Arkansas State Board of Pharmacy to review files pertaining to this application and related documents, and all law enforcement records, administrative records, and court documents to confirm the accuracy and completeness of the information provided herein. This application and signature shall act as authorization for entities in possession of applicable information to release such information to the Arkansas State Board of Pharmacy.

Signature of Owners/Representative: _____

Print the name of the Owner/Representative: _____

Position :_____ Date:_____

Company Name:_____

Checks should be made payable to: *Arkansas State Board of Pharmacy.*

Return the completed application and all related documents and fees to:

Arkansas State Board of Pharmacy
101 East Capitol, Suite 218
Little Rock, AR 72201

Website: http://www.arkansas.gov/asbp Telephone: 501-682-0190